Massachusetts Department of Public Health
Request for Alternative Means of Communication

Name: _____

Address: _____

Phone # _____ Date of Birth: ___/ ___/ ___

My request applies to the following program(s) (only the program(s) listed will be required to comply with this request)**:**

Program	**Location**

Requested Alternative Means of Communication:
[ ] Alternative Phone Number: _____
[ ] Alternative Mailing Address: _____
_____
[ ] Other Means of Communication: _____

My Request Applies to:
[ ] Communications about a single date of service only: ___/ ___/ ___
[ ] Communications from this date of service until further notice: ___/ ___/ ___
[ ] From ___/ ___/ ___to ___/ ___/ ___

_____ ___/ ___/ ___
Your Signature or Signature of Personal Representative Date

_____
Print Name

Indicate relationship of person signing this form to the individual who is the subject of the information disclosed.
___ Person signing is the individual

___ Person signing is the Personal Representative authorized to make health care decisions for the individual. Describe the authority _____

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Please note:
If your request is *granted*, the alternate address and/or telephone number you requested will be used for ALL future communications between you and DPH. The alternate address and/or telephone number will remain in place until the date designated above or until you change the restriction in writing. If your request was *denied*, this response will be made by the alternative means specified, and ALL later communications will be to your previous contact information.

DPH Only

DPH Decision

[ ] Request Approved

[ ] Request Denied
[ ] Request is excessively burdensome
[ ] Unable to accommodate request administratively
[ ] May prevent effective treatment
[ ] Additional explanation:

_____
_____

By:_____
Signature Title Date

DPH is required to inform you of your right to file a complaint about this decision.

With DPH:
Privacy Office
Massachusetts Department of Public Health
250 Washington St.
Boston, MA 02108
Phone: 617-624-6083

With the Department of Health & Human Services:
Regional Manager, Office for Civil Rights
DHHS Government Center
J.F. Kennedy Federal Building – Room 1875
Boston, Massachusetts 02203
Phone: 617-565-1340
FAX: 617-565-3809 TDD: 617-565-1343

Your complaint must be in writing, filed within one hundred eighty (180) days of when you knew or should have known of the denial, and name DPH as the party you are complaining against.